



**California State Board of Pharmacy**  
400 R Street, Suite 4070, Sacramento, CA 95814-6237  
Phone (916) 445-5014  
Fax (916) 327-6308  
www.pharmacy.ca.gov

STATE AND CONSUMER SERVICES AGENCY  
DEPARTMENT OF CONSUMER AFFAIRS  
GRAY DAVIS, GOVERNOR

## Financial Affidavit in Support of Application

All items of information in this application are mandatory. Failure to provide any of the requested information will result in the application being rejected as incomplete. The information will be used to determine qualifications for registration under the California Pharmacy Law. The official responsible for information maintenance is the executive officer, (916) 445-5014, 400 R Street, Suite 4070, Sacramento, California 95814-6237. The information may be transferred to another governmental agency such as a law enforcement agency if necessary for it to perform its duties. Each individual has the right to review the files or records maintained on them by our agency, unless the records are identified as confidential information and exempted by section 1798.3 of the Civil Code.

**Please print or type**                      **All blanks must be completed; if not applicable, enter N/A**

|  |                   |      |          |                   |
|--|-------------------|------|----------|-------------------|
| Name of Corporation, Partnership or Individual Owner:    |                   |      |          |                   |
| Address of Corporation, Partnership or Individual Owner: |                   |      |          |                   |
| Name of Pharmacy, Hospital, Wholesaler, etc:             |                   |      |          |                   |
| Premises Address:  | Number and Street | City | Zip Code | Telephone Number: |

|  |
|--|
| Indicate what part of the total investment will be in cash, and from what source(s) it will be or has been derived. <b>Please attach documentation.</b> \$ _____                 |
| Source: _____  |
| _____  |
| _____  |
| List all other sources of funding for the pharmacy and how it will be paid. Provide the name, address, telephone number and amount. Use additional sheets if necessary. \$ _____ |
| Source: _____  |
| _____  |
| _____  |

|   |
|---|
| If the pharmacy is franchised, list the name of franchisor: |
|---|

Who will be the **primary** wholesaler for dangerous drugs and/or dangerous devices? Please attach a photocopy of the **approved** application filed with the wholesaler.

Name of primary Wholesaler

Telephone number

Address of Wholesaler

Number & Street

City

State

Zip Code

Who will be the **secondary** wholesaler for dangerous drugs and/or dangerous devices? Please attach a photocopy of the **approved** application filed with the wholesaler.

Name of secondary Wholesaler

Telephone number

Address of Wholesaler

Number & Street

City

State

Zip Code

| Business Bank Name & Address<br>(list all accounts for the pharmacy) | Telephone<br>Number | Account<br>Number | Balance of<br>Account |
|--|---------------------|-------------------|-----------------------|
|  |                     |                   |                       |
|  |                     |                   |                       |
|  |                     |                   |                       |
|  |                     |                   |                       |

**Please submit a copy of most recent bank statement for each bank account listed above.**

List all individuals authorized to sign on business bank account.

| Signature | Name (please print) | Title |
|-----------|---------------------|-------|
|           |                     |       |
|           |                     |       |
|           |                     |       |
|           |                     |       |

Name of bookkeeper/accountant for applicant premises:

Telephone Number

(     )

Address of bookkeeper/accountant:

Number and Street

City

State

Zip Code

Estimated annual gross sales     \$ \_\_\_\_\_

Estimated annual purchases     \$ \_\_\_\_\_

## APPLICANT(S) AUTHORIZATION FOR DISCLOSURE OF FINANCIAL RECORDS

For a period of nine months, from this date, for the purpose of authorizing the Board of Pharmacy to conduct an investigation on my/our qualifications pursuant to section 4207 of the Business and Professions Code, I/we hereby authorize the Board of Pharmacy, or any of its authorized personnel to examine and secure copies of financial records consisting of signature cards, checking and savings accounts, notes and loan documents, deposit and withdrawal records, and escrow documents of my/our financial institution(s) or any financial records established in connection with this business.

I/we also authorize the Board of Pharmacy, or any of its authorized personnel, to examine and secure copies of any business records or documents established in connection with this business, including, but not limited to, those on file with my/our bookkeeper/accountant or with the escrow holder. I/we agree to furnish current financial information on the annual renewal if requested by the Board of Pharmacy. Applicant understands that falsification of the information on this form may constitute grounds for denial or revocation of the license.

I hereby certify under penalty of perjury under the laws of the State of California to the truth and accuracy of all statements, answers and representations made in the foregoing application, including all supplementary statements.

If corporation owned, one corporate officer must sign; if partnership owned, all partners must sign.

|  |                     |       |      |
|--|---------------------|-------|------|
| Signature of corporate officer, partner or owner | Name (please print) | Title | Date |
| Signature of corporate officer, partner or owner | Name (please print) | Title | Date |
| Signature of corporate officer, partner or owner | Name (please print) | Title | Date |
| Signature of corporate officer, partner or owner | Name (please print) | Title | Date |
| Signature of corporate officer, partner or owner | Name (please print) | Title | Date |

|      |       |                        |
|------|-------|------------------------|
| Date | Place | Attest (Notary Public) |
|------|-------|------------------------|